MENTAL RETARDATION SERVICES

PROGRESS NOTES - MEDICAL

Client Name Betty Wilson

DATE	PROB. #	NOTES
10/15/82		Doing fair. Still having tremors of hands but refuses to take more medicine. In fair contact. Rather withdrawn & secretive. No special complaints. Rx R.T.C. VIII wks. Dr Arangford
12/7/82		Doing about the same. Lives w her son, who is unemployed. Not very active during the day. Eats only from the refrigerator. Watches T.V. - alot. Appears guarded & suspicious. Rx R.T.C. VIII wks. Dr Arangford
2/8/83		Doing fair. Worried about gaining wt. In good contact. Affect is dull & mood slightly depressed. Denies delusions or hallucinations. Rx R.T.C. VIII wks. Dr Arangford

R-2-80
M-004 -1

BN000069

MENTAL RETARDATION SERVICES

PROGRESS NOTES - MEDICAL

Client Case Number [illegible]

Client Name [illegible] NELSON

DATE	PROB. #	NOTES
5-18-87		PT PRESENTED TO CAT STAFFING FOR TREATMENT PLANNING — CHART REVIEWED FOR COMPLETENESS — [illegible signature] Betty [illegible] RN [illegible signature] PhD [illegible signature]
6/8/87		Continues living c̄ her son & apparently doing fair. Watches T.V. most of the day & stimulation is practically nil. Denies delusions or hallucinations. Appears guarded & distant. No complaints at present. R.T.C. [illegible] wks Rx- [illegible signature]
8/3/87		"Doing pretty fair." Noticed to have fine tremor of hands & says she gets somewhat drowsy during the day. Eats & sleeps adequately. Not very active during the day & watches T.V. a lot. R.T.C. [illegible] wks Rx= [illegible signature]

R-2-80
M-004 -1

BN000070

MENTAL RETARDATION SERVICES

PROGRESS NOTES - MEDICAL

Client Case Number [illegible]

Client Name BETTY NELSON

DATE	PROB. #	NOTES
12-15-81		PT STATES SHE'S DONE WELL SINCE LAST VISIT - HAS MOVED SON TO A BETTER HOUSE CAUSE A BED OF NAILS, BEING MORE BETTER & SON - SLEEPING OK - APPETITE UNCHANGED - QUITE FRIENDLY TODAY - ANSWERS APPROPRIATELY NO SOCIAL ACTIVITIES - CAN'T COME TO GROUP DUE TO NO TRANSPORTATION - NO CPS - PLANNED TO SUMMIT LAB 2ms UDR.
2-19-82		Pt. doing fair. Says she has been somewhat restless during the day & feeling at times depressed. Pt. - prefers inactive at home & just watches T.V., etc. Will adjust Rx as needs. Rx - R.T.C. VIII wks.
4/6/82		Still feeling nervous & tense but to a lesser extent than before. Pt. presents sociable, & is rather reclusive & withdrawn. Affect is shallow. Rx: R.T.C. VIII wks.

R-2-80
M-004

MENTAL RETARDATION SERVICES

PROGRESS NOTES - MEDICAL

Client Case Number 714999

Client Name Betty Nelson

DATE	PROB. #	NOTES
11/19/81		See information supplied by S.A.S.
		SS y/o widowed W/F. returning to this clinic after a yrs absence. She says she went to S.A. to visit + stayed at the Salvation Army for a month. She also makes reference to having had a "heat stroke" + went to S.A.S.H. "for observation". Pt. has a Hx. of several psychiatric hospitalizations at T.P.S.H. + has been delusional, hallucinatory + grandiose in the past. Presently she is living with a son here - F.W + is taking Navane 5 mg bid. Supports herself with railroad retirement pension.
		On M.S. this is a quiet + cooperative middle age W/F. Non-spontaneous, but coherent speech. When pressured with definite questions she gets defensive + somewhat paranoid. Denies hallucinations, but she gives evidence of delusional thinking + loose associations. Judgment + insight are impaired.
		Imp. 296.64
		Rx- Navane 5 mg bid #60
		R.T.C. IV wks.
		A. Aranguren

R-2-80
M-004

MENTAL RETARDATION SERVICES

PROGRESS NOTES - MEDICAL

Client Case Number 7194919

Client Name BETTY NELSON

DATE	PROB. #	NOTES
11-26-80		PT IN IPSH - T-11 — [signature], RN
1-9-81		FAILED DDS APPT [signature], RN

R-2-80
M-004

TRINITY VALLEY MENTAL HEALTH
MENTAL RETARDATION AUTHORITY

PATIENT NAME Betty Nelson

CASE # 914999

6/10/80 Neat, clean & cooperative. Psychomotor activity somewhat accelerated. Admits to hallucinatory episodes — the past (saw Jesus' body. "He is tall, about 35 to 40 ft". Reports irregular sleep pattern. Reads mostly religious books & gets bored easily. Judgment & insight are impaired.

#100

Rx: LiCO3 – 300 mg ī AM ii HS
Advised to get Li. level a wk. before her clinic appt.
R.T.C. VIII wks (Nurse)
[signature] MD.

8/5/80 DNKA David Carpenter RN

8-22-80 Rx PHONED TO SUMMIT TO COVER UNTIL APPT —
LITHIUM 300 mg ī AM ii HS. #100
MA TO DR ARAUZO — TO HAVE LITHIUM LEVEL DONE PRIOR TO APPT
[signature]

9/1/80 Came an hour late for her appt. Says she had been robbed & had no money. Appears to be anxious & tense, & showing pressured speech. Denies hallucinations
Rx. LiCO3 - 300 mg ī AM ii HS
R.T.C. VIII wks.
[signature] MD

TRINITY VALLEY MENTAL HEALTH
MENTAL RETARDATION AUTHORITY

PATIENT NAME Betty Nelson

CASE # 914999

3-10-80 PT STATES SHE WAS REHOSPITALIZED FOR 2 WKS @ JPSH - STATES SHE HAD A SEVERE REACTION TO MELLARIL & COGENTIN IS NOW TAKING ONLY LITHIUM - STATES SHE'S SLEEPING & EATING WELL - NO BLURRED VISION OR FREQUENCY - HAS TRANSPORTATION PROBLEMS - WILL RTA ACCORDINGLY — CHANGED TO SUBSEQUENT LITHIUM 300 mg ī AM ī HS #100 LITHIUM LEVEL
RTA 1 MO - DR. Sally Cattercolon

4-14-80 FAILED DRS APPT
Sally Cattercolon

4-15-80 MISSED APPT SLIP - PT REPORTS SHE WAS HOSPITALIZED @ JPSH AFTER 3-10 VISIT - DR BRAMPTON PRESCRIBED NAVANE FOR HER - WILL RETURN TO JPSH 1st OF MAY - WILL BE HAVING EAR SURGERY HOSP HAS AGREED TO FOLLOW PT ON MEDS & DO LITHIUM LEVELS -
RTA 2 MO - DR. Sally Cattercolon

TRINITY VALLEY MENTAL HEALTH
MENTAL RETARDATION AUTHORITY

FEB 14 19

NAME: BETTY NELSON

CASE NO. 914999

DATE: 02-11-80

MEDICAL PROGRESS NOTES:

The patient was seen following the intake, 02-07-80. When she was seen on 02-07-80, she had just been discharged from JPSH, T/9, January 25, 1980 after a month-long stay. The hospitalization at JPSH was occasioned by marked and severe religious delusions, which led the patient to fast for almost a month, in the process losing 30-35#, and during which time she was showing insomnia, auditory hallucinations and various other bizzare activities noted on the intake note of 02-07-80.

Since discharge, at which time the patient was let go on 100 mg. Mellaril, q. a.m., and 600 mg., h.s., and which medications she has continued to take up to the present, the patient has improved as far as her psychotic state is concerned. The patient is no longer delusional, is no longer hallucinating, is eating well and sleeps well. However, the patient shows fairly severe extrapyramidal side effects from the 900 mg. Mellaril per day. The patient, when she entered the interview, was somewhat stiff in her gait and her affect was noted to be quite flat. The patient's mood was good, her only concern being the stiffness, the dryness of the mouth, blurred vision which will not allow her to read very well, and some intermittent difficulty with urination.

Other than the obvious extrapyramidal side effects, the patient appears, by history and by observation, to be doing fairly well. Her prognosis is, in my opinion, very guarded, but she lives with her son who does care for her and does watch out for any recurrence of symptomatology. The son is apparently fairly supportive of the patient.

MEDICATIONS: Mellaril will be reduced to 200 mg., b.i.d., #62, no refills.
Cogentin, 2 mg., q. a.m., #31, no refills.

REAPPOINTMENT: The patient will be reappointed in four weeks to the R.N..

Hal H. Frazier, M.D., Psychiatrist

HHF:pmt

R - 02-13-80
T - 02-13-80

TARRANT COUNTY MENTAL HEALTH
MENTAL RETARDATION SERVICES

CLIENT CASE NUMBER 914999

CLIENT NAME Betty Nelson

ADMISSION RECORD

I. Presenting Problem
II. Medications and Relevant Medical (May substitute Nursing Assessment)
III. Relevant Information
A. Subjective
B. Objective
IV. Conclusions
V. Impressions
VI. Initial Client Plan
VII. Identify Casemanager

(Use successive pages as needed - signature and date on last page)

I This client was referred to this clinic for med management following her discharge in Aug 1981 from San Antonio State Hospital. She was last seen in this clinic in Nov 1980. She states she ran out of meds on "Sept 27, 1981" due to missing 1st appointment here. In last 2 days has had initial and intermittent sleep disturbance. Currently living w son.

II was discharged on Navane 10mgm t BID. Pt states the doctors at SASH told her "not to take the lithium salt due to Heat Stroke Summer 1980" which aggravated her Double heart murmur and damaged my Heart more, it also caused my feet to swell. Client states she had rheumatic fever age 12 (Jul) Surgery on Rt ear (? mastoids" her statement) May 1980. See Nursing assessment for further data.

III Pt has a history of multiple hospitalizations and religious delusions. She says gave them (religious delusions) up when she left SASH. She has previously been dx as schizo affective and manic depressive. At present appears in remission. Was Oriented x 4, good recent and remote memory, speech pressured, answers to questions were direct and circumstantial, affect flat. no evidence of Tangential thought, delusions or hallucinations

R-9-81
E-001-1

SIGNATURE/TITLE OF INTERVIEWER/DATE

B. Brought visit from [illegible] staff Warene 10 mgm ī BID. It was

[illegible]. Smacked her mouth as if lips were dry. Talked in loud

manner: well dressed. Had to go ask son if she could come

in for nursing eval this Fri and seemed worried he would not

like it b/s he is [illegible] she has [illegible]

V. Due to orientation, memory, lack of tangential or excessive

thought process, denial of religious pre-occupation or delusion

it appears she is in remission at present.

I Based on past history in chart and from what little she

told me, I believe this is a schizo-affective Disorder

but can not r/o at present M-D illness. At present is in

remission.

VI Have set her up for Nursing evaluation with one of

our UTA-Nursing students this Fri Oct 14. Recommend

continuing med management. Discussed with her

possibility of TLC Social Club.

VII Julian Janes until picked up by Medical Services.

R-9-81
F-001-6

Julian Janes MSW 10/1[illegible]

TARRANT COUNTY MENTAL HEALTH
MENTAL RETARDATION SERVICES

CLIENT CASE NUMBER 914557

CLIENT NAME Betty Nelson

ADMISSION RECORD

ADDENDUM PAGE

III A. Additional Subjective data

Since being seen here last. She lived by herself in family trailer. In May 1981 moved to Salvation Army when "my son said he was going to put me in convalescent home" because "he said he was tired of bothering me". She lived at Salvation Army - F.W until July 1981 when she moved to Salvation Army in San Antonio because "I wanted to visit San Antonio". In late July 1981 a social worker took me to see "Dr Mc Nickle" who "asked me if I would go to "San Antonio State Hosp. Inst" for an evaluation". She states was discharge from SASH in late Aug 1981 (30 days). Returned to F.W now living w son ("he was living w a g and her 2 kids and she didn't like me") Son now lives alone. She sleeps on the floor ("we only have one bed" Son is trying to sell this house and they "plan to move back into a duplex my husband left me". She currently is without her glasses ("broke them") due to "don't have enough $ to fix them". Pt signed consent for release of info to SASH which I read to here. To be sent.

R-9-81
E-001-2

SIGNATURE/TITLE OF INTERVIEWER/DATE 10/15/81

MEDICAL INTERVIEW

Date Mar. 29, 1977

Name Betty F. Nelson Sex: M (F) Age 51

Chief Complaint Medication continuation

Referral Source Service Reception

Medical History:

Hospitalizations-

~~Last~~ Doctor's General Hospital (1970 (fainting spells)

Medications (Physician prescribing medications)-

Past- none

Present-

Epakelth 300 mg. 1 tid
Haldol 10 mg 1 @ hs
Colace 50 mg bid Cogentin 2 mg bid.

Surgeries and Injuries-

none

Allergies:

Foods-

Medicines- none

Others-

Habits (Duration, changes)-
Tobacco- No

Narcotics- No

Sedatives- No

Marijuana- No

Street Drugs- No

Alcohol- No

Coffee- No

Tea- No

Colas- No

1. GENERAL APPEARANCE:

Neat, clean, well-dressed, unkempt, dirty, disheveled, bearded, eye contact, long-haired, accelerated, retarded.

2. ATTITUDE:

Open, cooperative, aloof, evasive, suspicious, hostile, aggressive, demanding, defensive, friendly, superficial.

3. MOOD:

Depressed, anxious, elated, excited, apathetic, angry, calm, combative, flat, fearful, inappropriate, threatened, guarded.

4. ATTENTION:

Alert, distracted, pre-occupied, unable to concentrate, scattered, oriented, disoriented.

5. SPEECH:

Normal, rapid, rambling, disconnected, blocked, curt, brief, hesitating, flighty, slowed, retarded, loud, mumbling, incoherent.

6. SENSORIUM:

	Poor	Fair	Good
Orientation:			✓
Memory:			✓
Intelligence:		✓	
Judgment:		✓	
Insight:		✓	

7. ATTITUDE TOWARDS SELF: This pt. was too uncooperative.

Normal, guilt, pre-occupied with physical complaints, egotistical, feels inferior, feels unreal and abnormal, satisfied, wronged.

8. ATTITUDE TOWARDS PROBLEMS: unable to detect

Nothing wrong, worried, blames others, paranoid, ambivalent, guilty, embarrassed, confused, indifferent, seeks help, rationalizes.

9. INFORMATION:

Logical, well organized, circumstantial, illogical, inconsistent, vague, incoherent, delusional, incomplete, jumbled, confused.

10. MOTOR BEHAVIOR:

agitated, jittery

PERSONAL PROBLEMS

1 Yes Anxiety -

2 No Obsession/Compulsion -

3 No Phobias -

4 ✓ Marital Discord - Husband deceased 9/8/78 of heart attack after 17½ years of marriage

5 No Family Discord -

6 No School -

7 No Employment -

8 No Depression -

9 No Withdrawal -

10 Yes Hostility -

11 No Sexual Problems -

12 No Trouble with the law -

13 No Suicidal Thoughts -

14 No Homicidal Thoughts -

15 No Dissociation/Depersonalization -

16 Yes Poor Insight -

17 Yes Hallucinations

Auditory - Yes

Visual - Yes

INDIVIDUAL AND FAMILY MEDICAL HISTORY

1 N/A Seizures -

2 yes Nervous Conditions - Pt.

3 yes Migraines - Son

4 yes Diabetes - brother

5 No Kidney -

6 ___ Glaucoma -

7 ___ Thyroid -

Refused information

8 ___ Tuberculosis -

9 ___ Heart Disease -

10 ___ Cancer -

11 ___ Liver -

12 ___ DLMP -

13 ___ Reproductive Dysfunction -

SLEEP DISTURBANCES -

____Increased Sleep Duration:

____Decreased Sleep Duration:

____Disrupted:

____Nightmares:

____Difficulty Getting to Sleep:

____Difficulty Staying Asleep:

____Insomnia:

Refused information

____Reversed Circadian Rhythm:

APPETITE DISTURBANCES -

____Weight Gain:

____Weight Loss:

____Anorexia:

____Nervous Eating:

PSYCHIATRIC HISTORY

NONE -

HOSPITALIZATIONS - Elmwood

OUTPATIENT CARE -

FAMILY PSYCHIATRIC HISTORY -

SOCIAL HISTORY

MARITAL STATUS -

EDUCATION LEVEL -

EMPLOYMENT -

PEER GROUP -

HOBBIES -

HISTORY OF PRESENT ILLNESS: Pt. very angry uncooperative, demanding. Refusing to answer questions stated she did not need our help "God would help her." much hostility shown toward daughter. 17 y/o son lives with mother & states she is acting the same as before she went into hospital. Schedule to Dr. Stroud for re-evaluation. Suggest daughter & son come in for counseling. Pt. looked angry, posture very rigid & military, tone demanding.

Referrals:

Schelia Fuller, R.N.
Interviewer